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# **Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups**

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## **Running head**

Coping with depression in later life: a qualitative study

## **Abstract**

Depression is a common and serious disorder in later life and older people from minority ethnic groups appear low levels of service use. This study explores older adults' attitudes and beliefs about what would help in depression. In-depth individual qualitative interviews were completed with: older adults with depression who were treated (n=30); those who were not (n=37); and the non-depressed older population (n=43) across white British, black Caribbean, and south Asian groups. Analyses were based on grounded theory. The majority felt the responsibility for combating depression was an internal and individual task with support considered secondary. Cognitive techniques and keeping active were identified as self help strategies. Other sources of help included social support (family, friends and religion) and health and social services (primary care, medication, counselling, day centres and mental health services). The results illustrate the complex issues at work in seeking help for depression in later life identifying themes that are of importance across ethnic groups as well as those of particular salience in specific ethnic groups.

## **Introduction**

Depression is the most common mental disorder in later life, affecting up to 15% of those over 65 (Copeland et al., 1987; Livingston, Hawkins, Graham, Blizard, & Mann, 1990). This high prevalence appears to be shared by minority ethnic groups in the UK such as the South Asian and Black Caribbean elderly (Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001; National Centre for Social Research, 2002). It is therefore of concern that older adults from minority ethnic groups appear to have lower levels of service use compared with the majority population (Boneham & Williams, 1997). Suggestions of unmet need among elders from minority ethnic groups with depression (Ebrahim, 1996; Manthorpe, 1994) require an exploration of the potential barriers and facilitators to service use.

The process of help seeking, identification of need, help offering, and help accepting among older adults with depression is complex and poorly understood. Goldberg and Huxley (1980) described a succession of filters in the “pathway to care” that determine whether people access mental health services. Beliefs about the nature of the condition, and what is appropriate help, may act as barriers at each of these stages, influencing whether and from whom to seek help, the idioms for expressing the condition, and the acceptability of various treatments. This paper is focussed on these issues addressing the question “what is perceived as appropriate help for someone with depression?” which may, in part, underlie cultural variation in the way members of different ethnic groups respond to the experience of depression. The National Centre for Social Research (2002) reported that Indian and black Caribbean adults in the UK advocated “getting on with things” as a means of dealing with emotional distress. Karaz (2005) reported that South Asian immigrants in New York are more likely to avoid “thinking” about problems than to seek professional treatment. Cinnirella (1999) argued that a greater alertness to community stigma associated with seeking help for mental disorders might lead to a preference for private coping strategies (e.g. prayer) within ethnic minority groups, and religious practices have been identified as important ways of coping among black Caribbean and South Asian adults living in the UK (National Centre for Social Research, 2002). Therefore, traditional healers or religious

leaders may be considered a more appropriate and acceptable source of help than Western models of psychiatric care (Bhui, 1999; Cinnirella & Loewenthal, 1999) ).

In a focus group of Punjabi women, talking to friends and family was considered to be the first line of treatment (Bhugra, Baldwin, & Desai, 1997), while talking to counsellors, social workers or primary care physicians was held to be out of the question because of fears of loss of confidentiality. Research indicates that South Asian adults may not envisage primary care physicians (or General Practitioners [GPs] as they are called in the UK) as being able to help with psychological problems (Commander, Odell, Surtees, & Sashidharan, 2004). In one of the few studies exploring these issues in older adults, only black Caribbean (and not white British) respondents considered a primary care consultation to be an inappropriate response to depression (Marwaha & Livingston, 2002). However, Abas (1996) suggested that black Caribbean elders would welcome the opportunity to be genuinely “listened to” by professionals. Negative attitudes towards anti-depressants may discourage help seeking within minority ethnic groups (Schnittker, 2003). Furthermore, the black British community has been shown to hold negative perceptions of mental health services (Wilson, 1993). To date, little research has focussed on these issues in older adults from minority ethnic groups.

Service providers need to understand the beliefs that underlie help seeking behaviour in order to generate accessible and acceptable services. In this paper we present data from a study designed to explore older adults’ attitudes and beliefs about what would help someone with depression. We studied the perspectives of older adults with depression who have accessed treatment and those that have not, and the general older population amongst the three largest ethnic groups in the UK: white British, black Caribbean, south Asian.

## Method and participants

This was a qualitative study involving 110 older adults (aged 65 and over). The sample was stratified by ethnicity and by the participants' experience of depression. In-depth individual interviews were conducted with:

- (a) Older people with depression who were being treated (Depressed & Treated)
- (b) Older people with depression who were not being treated (Depressed & Not Treated)
- (c) Older people without depression (Not Depressed)

A "case" of depression was defined as a score of 7 or above on The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), which was developed to be unaffected by coexisting general medical conditions (Snaith, 1987) and reliable across medical settings and age groups (Flint & Rifat, 2002). Treatment was not limited *a priori* to pharmacological interventions (ie antidepressants) but in the event no participants were receiving psychological treatments alone. Each group included black Caribbean (BC), south Asian (SA) and white British (WB) older adults; this enabled us to compare and contrast attitudes among the two largest minority ethnic groups in the United Kingdom with the majority population.

Participants were identified through seven participating general practitioners (GPs), located in areas of varied socio-demographic characteristics (including those with a high concentration of black Caribbean and south Asian people). GPs provided access to information on age, ethnicity, and treatment status. Eligible patients were sent an invitation letter, followed with a phone call from a member of the research team. We also approached day-centres and lunch clubs for older people: four primarily serving the black Caribbean community, four serving the South Asian community and two predominately serving the white British community. A Research Worker discussed the study with the group and then recruited members individually, having determined their eligibility for the study.

Topics for the interview guide were generated from the literature. They were revised in an iterative way, incorporating new topics emerging from interviews. Following a detailed exploration of what the term 'depression' meant to participants, as reported elsewhere (Lawrence et al., in press), key topics included: what should someone with depression do; should they seek help and in what circumstances; what help might someone with depression need; who should help them and how? Participants were then asked to give their opinions on a range of treatments and services.

Information sheets, consent forms, the HADS and the vignette were available in four Asian languages: Gujarati, Hindi, Punjabi and Urdu. Interviews were conducted in participants' homes, unless they stated a preference to be seen elsewhere. They lasted around 1 hour and were conducted in the participants' preferred language. All were recorded on audio-tape and transcribed verbatim.

Analysis of the data was based on the grounded theory approach (Glaser & Strauss, 1967). Two of the researchers read the first five transcripts repeatedly to immerse themselves in the data; they then independently separated the data into meaningful fragments and identified and labelled emerging themes (as codes). Constant comparison technique was used to delineate the properties of the codes and to develop categories and sub-categories. The researchers compared their coding strategies and attempted to reach consensus. Any instances of disagreement were discussed and resolved by the wider research team. An iterative coding procedure was followed in which the initial coding frame was extended to include new themes as they were identified in subsequent interviews. NVivo Qualitative data analysis software (QSR International, 2002) was used to process the transcripts and enabled us to systematically identify, code and retrieve concepts. The number of interviews completed in each group was determined by "saturation of data", ie the point at which no new themes emerged from the

interviews. Table 1 shows the composition of the sample in terms of the key sampling variables.

[table 1 about here]

## **Findings**

### **SELF HELP**

The majority of participants felt that the responsibility for combating depression was an internal and individual task, with formal and informal support considered to be secondary or even inconsequential.

*I think the main helping with depression, any kind of depression, physical, mental, it's self help. If you help yourself the way you want to do it, you will get over the depression 100%, I am that sure. But if you don't want to do it, there's nothing you can do. Treat yourself. (South Asian / Not Depressed 13)*

Views on self-efficacy were unaffected by both ethnicity and experience of depression.

Members of all groups spoke about drawing strength from inner resources and the necessity of self-motivation and positive attitudes.

### **Cognitive techniques**

The belief that you must help yourself was manifested in the various cognitive strategies that were adopted to combat depression. A small number of depressed and non-depressed South Asian elders proposed that the most effective way to help yourself was to adjust your outlook on life.



*It's a mental attitude, mental attitude. If you change the mental attitude and all that and you become cheerful and start activities it will go. (South Asian / Depressed & Not Treated 12)*

The value of adopting a more positive outlook was stressed on a number of occasions. There was a tendency among black Caribbean participants to express the importance of putting “the past behind them” and to “concentrate on today”. This was seen as a difficult yet essential adjustment. Another strategy was avoidance. This involved actively putting negative thoughts and worries from your mind. The desire not to “dwell on things” characterised this approach.

*It's easier said than done, to not concentrate on one particular thing, especially bad things, especially bad things. Don't concentrate on it a lot. Let it go away as quickly as you possibly can. (Black Caribbean / Not Depressed 10)*

### ***Keeping active***

The most frequently cited technique for coping with depression was distraction. Participants spoke extensively about socialising and engaging in a wide range of activities as a means of taking their minds off negative thoughts.

*You think a bit differently you know with the way you think about things, it's different but I don't keep it in my mind. I like to read, I'm really interested in reading, papers, books, so then I forget everything. I kind of do it myself. (South Asian / Not Depressed 1)*

Hobbies and interests were universally recognised as a source of enjoyment, stimulation and something to look forward to. However, keeping active did not necessarily involve engagement in specific activities. The majority of comments communicated a distinct awareness that “it can be bad looking at the four walls every day” and “being cooped up alone is the worst possible thing”. Participants from all ethnic backgrounds explained that they often went out simply as an

end in itself, walking up and down the same roads, going for rides on buses and sitting in the local shopping centre. Others contrived reasons for going out.

*What you can do is, in the morning, if you want to go out shopping don't do all the shopping at one go. Say if you want milk, bread and sugar you should go for the milk only come back home and put it there. Have a rest for half an hour at your home and go out again, get the bread, then in the afternoon go out again. That way you kill 3-4 hours time. It's a very good psychological trick I learnt. It helps me a lot. (South Asian / Depressed & Not Treated 5)*

For those receiving treatment for depression, especially those of black Caribbean or South Asian origin, going out represented a valued opportunity to improve their mental health.

*Getting out of the house helps me enormously. I have been paying someone to take me out usually once a week, at the weekend, but she's moving to Norfolk and that's been sort of my life-saver because I thought I would go mad if I didn't get out the house...Yes, it's the one thing that is guaranteed to help. Well this is where I find it difficult now that I can't go out because all the ways that I used to help myself were getting out. (White British / Depressed & Treated 15)*

However, some recognised that the very essence of depression could leave the individual unable to “rise above it”. Those suffering from depression spoke of the inherent lack of motivation and energy that undermines attempts to remain active, to “make a big effort” and to “get on with it”. Depression often left sufferers painfully overwhelmed.

## **SOCIAL SUPPORT**

### ***Family***

Many participants, especially within the south Asian group, agreed that family support plays an important role in preventing and coping with depression. The nature of this support tended to

fall into two categories. The first was the contribution that family made to people's general well being. References were made to the pleasure derived from family trips and spending time with grandchildren. Secondly, there was the emotional support that was provided directly in response to individuals' depression. This took a number of forms: families listened, offered encouragement and advice, and occasionally sought professional help on their behalf.

There did not appear to be any distinct trend in the type of support received by different ethnic groups. However, it was striking that while those of white British background were the most frequent advocates of family support, they seemed to have lower expectations of receiving it.

*Well yes because they can help you by being there for you and you see, but young people haven't always got time to bother with you too much. I mean you have to understand that.*  
(White British / Depressed & Not Treated 10)

There was a reluctance to lean too heavily on family members, and recognition of clear limits to what was acceptable. A predominantly female white British group were loath to be an "added burden" to their family given that their "kids have got their own problems without adding to it".

### **Friends**

Great importance was attached to the value of social interaction. While a level of unanimity existed across the ethnic groups on this issue, there was apparent variation in the preferred nature of interaction. Participants of black Caribbean origin believed in the cathartic value of talking about their worries and concerns with friends. Friends were considered to be a source of encouragement, advice, reassurance and above all, through providing a comfortable environment to "talk it out", a valued outlet for distress.

*The first thing is communicating, that somebody is listening to what I am going through. You are pouring out your heart to that person and you feel a bit better that you have passed on your worries and problems to another person. (Black Caribbean / Depressed & Not Treated 11)*

White British and south Asian participants valued one-to-one chats as an opportunity to enjoy friends' company rather than as a therapeutic opportunity. A large, predominately white British, group emphasised the importance of "being with people", "mixing", "meeting people" and "making friends". It was implicit in many of these accounts that the onus was on the depressed individual to initiate such activity. Within these interactions, talking about your feelings was often circumscribed and individuals adopted an upbeat manner so as not to "depress other people".

*You've got to try and keep cheerful when you are with people, it's difficult, you want them to know but no I put on a brave face and make out I've got no troubles. If they ask me how I am, 'I'm all right, I'm fine' I don't, best to look on the bright side I find otherwise people get fed up, 'Oh she's a misery'. (White British / Depressed & Not Treated 2)*

Despite the widespread value placed on the support of friends and family, some black-Caribbean and white British participants were concerned that friends and family were constrained in their ability to help by a lack of understanding of depression. They feared that people might think badly of them, possibly seeing depression as "some kind of self indulgence on that person's part". Another major reason given for not discussing depression was the acknowledgement that the nature of depression might preclude it.

*Well it's hard to be talking to anybody, when the pressure is on because you don't know how to put your words properly. You don't, you can't explain how you feel. You are in a moody position all the time. (Black Caribbean / Depressed & Treated 9)*

## **Religion**

Religion was thought to help people cope with depression in a number of ways. Black Caribbean participants described a distinctive relationship with God. Having a “personal relationship with your Father” meant communicating with God in a direct and informal manner.

*But of course, religion means that you are in talk with God and if God can't help you what else will help you? God will help you if you believe in him. (Black Caribbean / Not Depressed 9)*

Many Caribbean elders reported religion to be central to overcoming depression, some asserting that the absence of a relationship with God, underlined by a lack of faith, would prolong suffering. Black Caribbean participants also set store by the support networks incorporated into their religious way of life. For a number of South Asian older people of Hindu, Sikh and Muslim faith, “going to the temple” represented a fundamental aspect of their lives. The value of meeting friends was juxtaposed with the value of “putting your mind with God”. Visiting the temple, praying and meditating were considered to bring a sense of peace and calm that would help you throughout your life, including when depressed.

## **HEALTH AND SOCIAL SERVICES**

### **General Practitioners**

Within each ethnic group the number of participants making positive and negative assessments of GP's management of depression was approximately equal. Black Caribbean participants presented as both the chief advocates *and* critics of GPs; South Asian participants were the least positive *and* the least negative of the GPs contribution whilst the assessment made by white British participants fell midway between the two. Differing expectations of the GP role may underlie the apparent polarity within the ethnic groups.

Among the black Caribbean group, broad criteria for consultation were given: “not feeling well” or “not functioning right” justified seeking help. A large proportion of these participants believed that going to see their GP was an opportunity to discuss their worries and concerns. While they praised GPs for this service, they were highly critical of GPs spending insufficient time with their patients or appearing to take insufficient interest. The dual belief that GPs *could* and *should* help together with the experience that they often *did not* help resulted in polarised positive and negative evaluations.

*You see the GPs are so tied up with so much work they don't have time to talk to their patients and they find a lot of people don't get the necessary benefit that they would get from the GP if the GP talked to them. Even give them less medication and have a talk because it makes them feel good within themselves you see and that feeling within themselves is like a self-healing power you know. That builds them up. (Black Caribbean / Depressed & Not Treated 3)*

South Asian participants expressed the most deferential attitudes to GPs, valuing them as a source of knowledge, for prescribing medication or referring for further help if required. However, in contrast to the black Caribbean group, there was little evidence that this was a service valued for depression. White British participants held more diverse opinions, variously describing the GP as somebody who would listen, give information and advice and provide medication and referrals.

Reservations about seeking help from GP's and criticisms regarding their practice were similar across the ethnic groups: doctors were too busy; they were overly reliant on medication as a form of treatment, and it was the patient's responsibility to change. Others explained that limited GP consultation time forced them to prioritise their physical, rather than their psychological, complaints.

*There's so much to say and so little time. So you always feel like you haven't got enough time with the doctor. Yes so then you think to yourself, ah well, the important thing, first, cure your pains and then think about the depression later on. (Black Caribbean / Depressed & Treated 3)*

Compromises of this sort were viewed as regrettable but inevitable in such an over-stretched service. Others described instances when their GP had dismissed their complaint as being a normal part of ageing, reinforcing their belief that the elderly have low priority in the health service.

It was striking that participants who were being treated for depression assessed GP's contribution most negatively. Conversely, non-depressed older adults evaluated GPs' ability to manage depression in the elderly most positively. Those who were currently depressed but not receiving treatment were ambivalent in their views of the role of GPs. Although initial remarks tended to be positive, they often went on to express dissatisfaction about the amount of time and attention devoted to older patients like themselves. There were also concerns regarding whether experiencing such problems "at their age" warranted a GP's attention; this reflected low expectations of help for their condition as well as the high value that they attached to GPs' time.

### ***Medication***

Participants from all three ethnic groups positively endorsed medication for the treatment of depression, with white Britons expressing this view in the greatest numbers. Descriptions of its benefits included "calm the nerves", "ease the pain", "build up the strength" and "help you lead a normal life". Medication was generally depicted as a temporary crutch although a minority recognised it as an essential constant in some people's lives. The greatest fear associated with medication was that it could create dependency.

*I mean you hear of people taking these drugs for years and years and they get so dependent on them. (White British / Depressed & Not Treated 3)*

Those who were currently depressed but not receiving treatment were the least positive about the value of medication and the most fearful of dependency. There were also common concerns about side effects such as dry mouth, nausea and decreased libido. South Asian participants in particular appeared to view side effects as inevitable and were reluctant to take medication for this reason. Others were reluctant to be “a pill popper” and believed medication signified the severity of the condition.

### **Counselling**

There was strong belief in the benefits of counselling and psychotherapy for those suffering from depression. There was a tendency to conceive counselling as an opportunity to express feelings, to talk and to “relieve some of the stress that you are carrying around with you”. Participants from black Caribbean backgrounds expressed this view emphatically.

*When you get a counsellor to talk to you, what the person says to you is encouraging, strengthen your body, strengthen your mind and whatever is there, it come right out. (Black Caribbean / Depressed & Treated 2)*

The attraction of counselling often lay in the opportunity to speak to a professional who was distanced from the situation.

*Someone from outside has a better view on things and more impersonal views, so he might be more open than sort of people who know, you know, of like things about you and you just react in a different way I think. You are concerned about your relationship with them rather than focusing all the time about yourself and getting that out. (White British / Not Depressed 5)*

However, only a small number had any direct experience of counselling and very few spoke of the value of specific theoretical approaches. While some participants, often of South Asian



origin, were confused about the exact role of counsellors, they tended to expect that company, advice and a protected time with counsellors would be beneficial. Counselling services were also seen as potentially helpful in reducing the pressure on GPs' time.

*Counsellors would be able to spend more time with them, to chat with them, to make them feel at home and things like that you know. Whereas a GP, they would be considered to be an official, authority, while these counsellors are normal people who give their time in counsel. I suppose that's what it is, so that would help them, the counsellors would be more helpful.*  
(South Asian / Not Depressed 10)

However, there was also some scepticism and apprehension surrounding counselling. Among South Asian participants there was a strong belief that it would be inappropriate to discuss personal problems, perhaps concerning family members, with strangers.

*No I don't think you should take what's going on in the home outside of the home, I think you should keep what goes on in the home at the home.* (South Asian /Depressed & Not Treated 7)

### **Day centres**

Those that had attended day centres or lunch clubs valued the opportunity to meet people, to occupy one's mind, exchange opinions, play games, laugh and joke. Organised talks, excursions and activities were also praised. There was a consensus that their value lay in the chance to get out of the house and be with people. For some, this represented their only contact with the outside world and inadequate day centres were occasionally endured for this reason.

*Day centres take the sting out of it anyway, even if you sit there and say nothing and there's nothing to do, you are at least with other human beings.* (White British / Not Depressed 17)

While the principle of day centres was widely supported the reality was often criticised. Some reflected that attending day centres simply entailed meeting others who were depressed. Others felt patronised by staff, who were also criticised for failing to organise stimulating activities.

*My feeling all the time and my feeling still is, that they go for the lowest common denominator, intelligently. You are pushed down. You know for some reason you are as not as bright as they are...Yeah. Quite patronising really. (White British / Depressed & Treated 15)*

However, a large number of centres were considered to provide an excellent service and many individuals were distressed about the threat of closure. There was agreement about inadequate provision of places and fear that this was going to deteriorate further. Others complained that it was difficult to acquire information about day centres. One claimed that resources existed only for ethnic minorities in her area.

### ***Psychiatrists***

Just over one in ten participants recommended seeking help for depression from a psychiatrist. As with medication, this was seen as a testament to the severity of the condition and some were explicitly concerned with the stigma.

*I would feel that if someone was to say we are going to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing. (White British / Depressed & Not Treated 1)*

Some participants explained that their desire to avoid psychiatric referral had motivated them to overcome the condition. However, those who had regular contact with psychiatrists often described the reassurance of monitoring and the opportunity to speak frankly about their condition.

## **Discussion**

The results of this study illustrate the complex issues at work in seeking help for depression in later life. Before discussing the data generated here it is important to consider the limitations of this study.

The main limitation is one of generalisability. The sample was drawn from urban south London and so it may be that the data are not generalisable to older people living in small towns or rural areas outside London. Equally the data were all collected in the UK and so there may be different issues in south Asian and black Caribbean elders in different countries. However most older adults from minority ethnic groups live in such urban areas and individuals were recruited from five south London boroughs in which a very broad range of socio-economic and ethnic diversity exists; including deprived inner-city areas and wealthy suburbs. It is therefore likely that our findings have reasonable theoretical generalisability to black Caribbean, south Asian and white British older adults living in the UK. Clearly there will be major variation between countries but it is likely that the themes generated here will have some relevance to these populations in other developed economies such as the USA. Second we focused on three ethnic groups only. These were chosen on the basis of their being the largest in numbers, but this choice does mean that we cannot comment on other minority ethnic groups such as those of Chinese or eastern European origin. Further research is needed in these groups. Finally we have carried out a large number of interviews and have chosen to present broad data on the whole group to enable comparison. This means that we have had to balance breadth of data with depth of analysis. However with this and the other limitations it is of value to consider the paucity of evidence in this area. The data presented here are intended to identify and enable discussion of key broad inclusive themes that can inform further more detailed studies of cultural differences in help-seeking in depression in these and other minority ethnic groups in the UK and worldwide.

Our participants stressed personal responsibility for coping with depression above all other strategies, and that forcing oneself to get out and engage in activities was the most effective means of self-help. We found less of a focus on cognitive strategies compared with working age adults (National Centre for Social Research, 2002), suggesting that older people tend to adopt a more behavioural approach to tackling the experience of depression. While there is much that may be positive about a focus on self-help for depression in later life, the fact that up to one in six older adults are depressed at any time suggests that this is not an effective strategy in itself. Public education should communicate that the nature of depression often necessitates help from others, and that general practitioners are ideally placed to begin the process of finding support that could enable individuals to help themselves. Our findings suggest that older people would be positively inclined to strategies that encourage efforts to interact and remain active, and these may provide a useful mutually acceptable adjunct to pharmacological and psychotherapeutic interventions.

The tendency of South Asian participants to identify families as a prominent source of help for depression is consistent with previous research in younger age groups (Sonuga-Barke & Mistry, 2000). Among the white British population, the qualifier that families are constrained by their own commitments frequently accompanied the belief that families should help during difficult times. Despite rationalising the situation in this way, many white British elderly were left longing for increased family contact and support. The black Caribbean group placed less emphasis on the role of the family but stressed the cathartic value of discussing worries and concerns with friends, suggesting a willingness within this group to discuss emotional problems in a candid way.

Our results echo the finding in younger age adults and mixed age groups of the importance of religion in helping many black Caribbean people cope with emotional distress (Cinnirella & Loewenthal, 1999; National Centre for Social Research, 2002). Practising faith was seen as the responsibility of the individual and prayer was allied to the concept of self-help. Whilst lack of

faith was not explicitly presented as causing depression, it was implied that without a true relationship with God, depression would be difficult to overcome. Seeking informal or formal help might signify insufficient faith in this context. Health care professionals may need to work closely with religious leaders if they are to challenge these deep-seated beliefs.

The literature suggests that younger South Asian people tend not to medicalise emotional distress (Beliappa, 1991; Fenton & Sadiq-Sangster, 1996). The South Asian group within our study was most likely to conceive the GP role as limited to prescribing medication and making referrals, and that the nature of depression is incompatible with this role. This may account for the tendency among South Asian older adults to remain uncritical of GPs despite evaluating them as rarely helping with depression. Promoting the concept of depression as a treatable medical condition might resolve this problem and help legitimise help-seeking. However, there is a need for delicate individual negotiation given that this may feel at odds with individuals' interpretation of depression. It is also likely to be of value to reassure older adults that it is appropriate to voice concerns about their emotional state in a GP consultation.

The idea of counselling was embraced by the black Caribbean group in particular. Their limited experience of counselling paralleled that of other groups, yet their greater enthusiasm possibly reflects the high value placed on confiding in others (Priest, Vize, Roberts, Roberts, & Tylee, 1996) and being genuinely "listened to" (Abas, 1996). To varying extents, participants communicated both a willingness and desire to discuss how they feel, and it was this sort of help that was most widely praised. This was especially pronounced amongst the black Caribbean participants, yet members of all groups valued the opportunity to talk, without fear of boring others, becoming a burden, or being judged. This has implications for referral to practice counsellors and practice nurses. It also suggests that active probing might precipitate depressed older adults to enter into a dialogue with their GPs about how they feel.

Psychiatrists were generally regarded negatively and participants were conscious of the stigma attached to receiving help from this profession. This was especially pronounced within the ethnic minority groups as reported in other studies (Rack, 1982). There is a need for education concerning the role of psychiatrists, as well as for increased information regarding the actual risks of dependency and side effects associated with medication.

Those participants who were receiving treatment for depression were least positive about the GP contribution. This was partly due to a feeling that medication represented an insufficient response to their needs. It has been reported that groups receiving treatment for depression are more prone to adopt medical models of depression that conform to the GPs approach (UMDS MSc In General Practice Teaching Group, 1999). However, our sample of older adults appeared to attach greater significance to the role of psychosocial factors. Medication was cautiously advocated across the groups, but these findings underline further the need to develop a wider psychosocial response to depression in older adults if we are to provide services which are acceptable to those that need them.

**Table 1: Socio-demographic characteristics of participants**

	Ethnic group		
	Black Caribbean	South Asian	White British
<b>Total</b>	32	33	45
<b>Treatment status</b>			
Depressed and Treated	9	6	15
Depressed and Not Treated	13	12	12
Not Depressed	10	15	18
<b>Origin</b>			
Indian	0	20	0
Pakistan	0	3	0
East Africa	0	7	0
Caribbean	32	0	0
United Kingdom	0	0	45
Other	0	1	0
<b>Gender</b>			
Male	10	9	19
Female	22	24	26
<b>Age</b>			
65-70	12	17	8
71-80	13	11	26
81-90	6	5	10
90+	1	0	1
<b>Religion</b>			
Christian	27	3	42
Hindu	0	20	0
Muslim	0	5	0
Sikh	0	5	0
Other	5	0	3
<b>Interview language</b>			
English	32	20	45
Hindi	0	10	0
Punjabi	0	2	0
Urdu	0	1	0

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